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IN CHILDREN.BEING A COURSE OF LECTURES PREPARED FOR DELIVERY DURING THE SPRING
SESSION OF 1862 IN THE COLLEGE OF PHYSICIANS AND SURGEONS, N. Y.

BY THE LATE

C. VAN ALLEN ANDERSON, M.D.,

PHYSICIAN TO CHILDREN'S DEPARTMENT, DEMILT DISPENSARY, N. Y.

LECTURE II.—PART III.

CROUP—ITS PATHOLOGICAL ANATOMY, ETC.

THE progress of croup is nearly always regular; it may be estimated by the description which I have given you, beginning with a preliminary stage, going on to one of development, and ending in the period of collapse. But towards the end of the second stage there may be one or more well marked remissions, when the efforts of coughing or vomiting eject large portions of the false membrane. The child then for a few hours enjoys tranquillity, until the morbid concretions are again exuded in the air passages, and dyspnoea once more begins. The *duration* of the disease cannot be accurately stated; it depends not only upon the intensity of the inflammation and the vitality of the child, but also upon the consecutive bronchitis, pneumonia, or other complications which frequently bring on its fatal termination. Dr. West has seen death occur in thirty-six hours from the appearance of the first symptoms. Prof. Gölis, of Vienna, mentions the case of a child who expired in fourteen hours; and Dr. Hamilton, on the other hand, has seen it last nine or ten days. It usually, however, runs its course in three, four, or five days; and from three to six days would include the greater number of cases.

The fundamental anatomical character exhibited on dissection of a patient that has perished from this disorder is the presence of a false membrane on the mucous surface of the larynx. It is of considerable consistence, of a whitish or yellowish color, and of varying thickness, lining the larynx, it may be the trachea, and sometimes even reaching down to the bronchi. Its external surface is smooth, the internal one which is applied to the mucous membrane is rough, and dotted over with numerous reddish points. In some cases it is of small extent, looking like little patches between which the inflamed membrane may be seen, and situated in different parts of the air tubes; in others it forms either half cylinders, or else complete casts of the parts, though such a full deposition of it is rare. It is usually thinner in the larynx, and those portions of it which are discovered in the bronchi are very friable. If there be no exudation of puriform matter beneath it, its adherence is remarkable, the mucous coat being often raised in an attempt to strip off the false membrane. Its chemical reactions are these—it is quite insoluble in both cold and warm water; sulphuric, nitric, and hydrochloric acids harden, shrivel, and coagulate it; liquid ammonia, acetic acid, and alkaline solutions in general dissolve and convert it into a diffuent mucus; it is therefore evidently albuminous in its nature.

The best theory that has been presented to account for this production of false membrane on a mucous surface, is that of Dr. C. I. B. Willard. He is disposed to refer the exudation of lymph to the inflammation affecting the sub-mucous cellular tissue, and being at the same time diffused like the inflammation of erysipelas. The matter effused, he thinks, is thin enough to penetrate through the mucous membrane, and becomes concreted upon its surface. The delicacy of this structure in children facilitates the transudation in deep-seated inflammation, hence at an early age all such inflammations may cause the effusion of a fibrous matter, as in croup.

Besides the presence of this abnormal formation, we
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behold in all cases evidences of inflammatory alteration of the mucous membrane. It is of a bright red color, particularly about the edges of the rima glottidis, the arytenoid cartilages, and sacculus laryngis, swollen, vascular, and easily peeled off. Occasionally there are patches of ecchymosis around the orifices of the mucous follicles, the mouths of which are frequently dilated. They give the membrane a dotted appearance, and they are larger in the direction of the longitudinal fibres of the trachea. The same swelling and vascularity which are distinguished in the larynx may also be found in the course of the trachea towards the primary division of the bronchi.

Although these are the principal morbid changes which you will observe, other post-mortem appearances will be found depending on the complications or the modifications of the disease. Thus the pharynx may have pseudo-membrane upon it, either disposed in patches or continuous with that found in the larynx, or, as in two cases given by Brétonneau, invading the oesophagus as far as the cardiac orifice of the stomach. Alterations of the stomach and bowels are never found; but the lungs present the most frequent evidences of disease. The bronchi are inflamed even when there is no false membrane in them; the mucous membrane is red and softened, or else it is much congested, and the tubes contain a muco-purulent or purulent secretion. In a large proportion of cases the lesions of pneumonia are found; in many an emphysematous condition of the pulmonary tissue, which has resulted from the asphyxia preceding death; and from the same cause the right side of the heart and the veins may be filled with blood.

From these foregoing observations and pathological appearances, then, we may rationally conclude that croup is an inflammation of the mucous membrane and of its cellular tissue, producing a characteristic albuminous discharge, concreted upon its surface by the effect of the temperature, the passage of air over it, and its own nature:—that there is always present a spasmodic action of the muscles of the larynx diminishing the calibre of the canal through which the air passes to the lungs—that a fatal issue is not always caused by the quantity of the false membrane; but that it is sometimes due to spasm, and the necessary results of interrupted respiration—and that when we are called to a case of croup we have to meet a most distressing and dangerous disease; one that in the majority of cases destroys life in spite of our utmost care and skill.

Croup may assume characters differing from those which I have given above, because one element of the disease may predominate over the others—in other words, we may have two modifications.

I. Croup with a preponderance of the inflammatory symptoms, prevails in robust children of a sanguine temperament. It is preceded by chilliness and rigors, is the severest form of the disease, is marked by continuity of the symptoms, the absence of remissions, hardness and rapidity of the pulse, great heat of skin, redness of the cheeks and lips, extremely difficult and forcible respiration, and if blood be drawn, by the buffy coat being found upon it. The disease may be confined either to the larynx or trachea; in the former case the respiration, voice, and cough all exhibit the strongest symptoms, the pain and swelling of the larynx are very noticeable, and convulsions sometimes come on, the attack terminating unfortunately even in so brief a time as twelve hours. If, however, the trachea only be implicated, the progress of the disorder is less rapid and fatal. The cough is not so brazen, the voice not so hoarse, the difficulty of respiration less, and the feeling of impending suffocation not so oppressive. There is violent fever present, and pain is usually felt along the course of the trachea, or a burning sensation in that region is complained of. The attack may be prolonged; twelve or fifteen days' treatment partially subdues it; but the patient is carried off in a relapse, or else the acute symptoms subside, and the malady assumes a decidedly chronic character.

II. Croup with a predominance of the nervous symptoms is far more manageable, provided it be taken early. The complaint may come on with the ordinary preliminary stage, or in other cases the patient may be suddenly attacked with brassy cough, hoarseness, and dyspnoea. There is always fever present, though it is not so intense as in the last modification; but the distress of the child is quite as great. The nocturnal exacerbations and daily remissions in this form will strongly attract your notice; but by prompt treatment I believe you may sometimes relieve the spasm and mitigate the inflammation before the false membrane has time to form. Some of you who are in the habit of observing the practice of the Demilt Dispensary, will, I am sure, remember the case of a little boy three years old who was brought there last December, suffering with the usual symptoms of this disease. He had been seized about five hours before he came under our observation, with the brassy cough and dyspnoea—his skin was very hot and dry, and his pulse was 156; there was also some lividity about the lips, and his general condition gave us very slight reason to suppose that we could check the progress of the disease—indeed, we were forced to consider the early performance of tracheotomy as the only possible chance of saving his life. Active treatment was immediately begun, and after five days, during which the difficulty of respiration slowly increased, I had the satisfaction of seeing the dangerous symptoms yield, and the child begin to recover without an operation.

Croup may be complicated with other diseases, or may be itself secondary to them. Of those which complicate it, you will have gathered from what has been already said, that affections of the bronchi, and of the structure of the lungs—in other words, bronchitis and pneumonia—are oftenest met with. Bronchitis is found in young and delicate children, and is associated with catarrhal symptoms. Though the signs of croup are all present, those of bronchitis are added to them; thus there is more wheezing in the chest, more expectoration, and dry and moist râles are heard usually in both lungs. Both affections combined are of course more dangerous than either taken singly; though the croup may yield to the inflammation of the bronchial tubes, or on the other hand the bronchitis may disappear before the laryngeal trouble. But it generally develops into the commonest and most dangerous complication of croup and pneumonia, fearfully increasing the peril of the preceding malady. This does not occur in the early stage, but happens towards its termination. Its detection is not always easy, for it may be confined to a small portion of the lungs instead of being general, and the loudness of the croupy sound over the whole thorax may greatly interfere with our auscultation. Its access is announced by an increase of fever, and a more rapid sinking of the vital powers; but we should not wait for these signs, a competent physician will take pains to make himself thoroughly acquainted with the condition of his patient's lungs every day.

Croup is sometimes observed in connexion with hooping cough, phthisis, measles, small-pox, scarlatina, and diphtheria. Mr. O'Ferrall met with two cases of its occurrence in the epidemic of scarlet fever which prevailed in Dublin in 1834. "Croup occurred," says he, "in two instances, in which, notwithstanding the opinion of Mons. Trousseau, I could not doubt its origin in scarlatina. . . . One child who recovered ejected the false membrane (which I still preserve) in a tubular form and presenting a cast of the trachea a little beyond its bifurcation. In a child who died, patches of false membrane were also ejected; but she sank exhausted, and the disease was afterwards discovered to have extended far into the bronchial ramifications."* Croup complicating scarlet fever makes its inroad about the time of the appearance of the eruption, or soon after.

At our next meeting, gentlemen, I propose to consider

the diphtheritic form of croup; the diagnosis of it particularly from Laryngismus Stridulus or False Croup; its prognosis and treatment; and then, with your permission, to commence the study of pertussis or whooping-cough.

Original Communications.

REMARKS ON AMPUTATIONS.

By DEWITT C. PETERS, Asst. Surg. U.S.A.

MR. SKEY, in his instructive work on operative surgery, uses the following impressive language:

"Amputation is the last resource of the surgeon—at once the shelter and confession of the incompetency of surgical art. The knowledge and skill of the surgeon fail to cure a disease, and he is reduced to the necessity of removing the entire portion of the body of which it forms a part. If such a disease prove incurable in his hands, he is justified, in obedience to an imperative law of nature, which dictates the desire of prolonged life, in removing it, with a view to preserve the mutilated relic. There is no operation in the whole range of surgery compared to that of amputation, that should claim the previous exercise of an equal amount of skill, of patience, or the decision on which demands so large an amount of conscientiousness. The most experienced are yet but students."

The era of promiscuous surgery both in military and civil life, has passed nearly, if not quite, into oblivion. It is with pleasure we read and witness the rise of our science in common with its kindred associations in the arts, until the present half century is reached, when we find it resting on a sound basis, and supported by established laws and precedents. The surgeon of to-day who would thoughtlessly or recklessly sacrifice a limb in preference to making the exertion to save it, does so at the peril of his professional reputation. He meets the condemnation of his fellows, and renders himself amenable to the laws of the land. The exigencies of the battle-field no longer shield ignorance or rashness, and it must only be viewed in the one light of being the chosen spot where we are to exercise our highest endowments, keen judgment, skill, and discrimination, in saving both life and limb. In the trying emergency when the army surgeon is surrounded in countless numbers by his wounded fellow-beings, he wields a power for good or evil unknown to any other calling. Suspended on his efforts are the great issues of prolonging and saving life, and, lastly, that of preventing deformity, and hastening recovery. Surely, then, he should be master of his position, and feel confidence in his abilities to accomplish the most good with the least means.

The question of the preference or advantage of primary over secondary amputations in certain cases resulting from gunshot wounds, notwithstanding the statistical evidence of a list of surgeons headed by Mr. Guthrie, is, and probably will be for a long time to come, open for discussion. The theory of John Hunter that "amputation is a violence superadded to the injury, and therefore heightens the danger," continues to have its followers, and seemingly it is not wanting in a degree of plausibility. In this instance, however, like unto several disputed points in our science, rarely the truth lies in an excessive faith for either side, but rather in choosing for our guidance a middle and safer course. There are circumstances encountered in a variety of cases met with on the field, which in their investigation cause a deviation from any rule established upon incomplete statistics, or else the surgeon sinks to the rank of a mere routine operator. It was the early practice of military surgeons to resort to primary amputations indiscriminately, and it was then the easiest and best mode of relieving the wounded. The treatment of wounds and fractures was not so well understood by these ancients as by ourselves, and, lacking

* Graves's Clin. Med., vol. 1, p. 321.

army hospitals, the wounded were thrown upon the communities where they chanced to be, and it is to be supposed they received very little surgical care. In his unparalleled military experience, Larrey, no doubt, had his attention drawn to the fatal results following this general system of amputating, for on one occasion, after a great battle, he is reported to have dressed compound fractures of the leg with sheaves of grain, there being no other and better material to use as splints at his command. The fact is stated that towards the close of his career he was more cautious in resorting to the knife than he had previously been. The existing war in our own country is doing much to elevate conservative surgery, and in no one particular point more than in deterring army surgeons from amputating without first seeking consultation. The conservative course instituted by these surgeons has been materially aided by the grand system of General Hospitals, which, like magic, have sprung up in our midst. Their number, capacity, and perfectness in detail, are at the same time the wonder and the pride of the nation. To the wounded soldier they are asylums where his flagging energies are revived, his hopes restored, and his wounds cured. They may be justly styled the spinal column to the army, and from sickness and injury they have stayed its decimation.

It is, well authenticated in surgery that there is a material difference in the results following amputations performed on the battle-field, and the same operations performed in well organized civil and military hospitals. The operations may be executed with equal care and skill, yet on the field, under this severe surgical interference, the patient is prone to die. The reason is obvious, and is readily accounted for in examining the subject. A soldier after long and fatiguing marches, deprived of his rest, submitting quietly to irregularities in his diet, is suddenly ushered into a state involving great mental excitement; he over-exerts himself in the performance of his duty, and finally, struck down by a bullet, falls bleeding, and perchance badly wounded. The condition of such a person, when seen by his surgeon, is far from being desirable, nor can it be equal to the increased shock which amputation implies; therefore succeeding the operation, reaction frequently cannot be established, and he must and does succumb. If, on the other hand, the reaction is slow, yet certain, the difference is only slightly in the patient's favor. He lacks the solid comforts and the coveted auxiliaries with which our General Hospitals abound, and he must be transported to receive them. The movements of a large army in a field of active operations require it to be relieved of its sick and wounded, and to a limited amount only can the supplies needed by them be conveyed. In consequence of these tangible reasons the indications in the treatment of recent amputations on the battle-field are violated in two very important points, viz. the parts are deprived of their natural rest and quietness. The sequel following the disturbing the patient at this period is, that he may live to reach a General Hospital with his vital powers nearly extinguished, or his strength so reduced that he is a fair subject to contract gangrene or any complication tending to lessen the chances of recovery. In the present undecided state of our experience, we are unable to determine whether many of our patients could more advantageously bear the transfer to a General Hospital in the first instance, and undergo the operation of amputation subsequently, or *vice versa*. These remarks are intended to apply directly to cases of gunshot wounds of the lower extremities, although their import reaches, to a certain degree, similar wounds of the upper extremities. The latter, however, are less dangerous to the patient, are followed by a weaker shock to the nervous system, and are considered by surgeons far more favorable for primary amputation than the former. In this connexion it may be proper to call attention to the peculiarities noted in the constitution of some men to bear injuries, loss of blood, and severe surgical operations, better than the majority of their comrades. The same ano-

malous power is possessed by a few persons, when injured, to retain their strength under transportation from one point to another. In the spring of the year 1855, while serving in the Rocky Mountains against hostile bands of Utah and Apache Indians, I had charge of a soldier who had been badly wounded in the right knee-joint. By the force of uncontrollable circumstances I was not, at the time the injury was received, allowed to amputate. He was transported in a litter, supported and carried by two mules over a rough trail for the sixteen succeeding days. His equilibrium was not in the least disturbed by the journey, and on reaching our fort I placed the man under an anæsthetic, amputated his thigh, and had the satisfaction of witnessing his rapid recovery.

The mode of amputating, and the steps to be taken at each place of election, are matters clearly detailed by our text-books on surgery, and need not here be minutely recapitulated. The opinions of eminent surgeons, however, are at variance somewhat as to the exact shape of the flaps to be made in amputating, and also as to the manner of making them. The rule laid down, and practised by many skilful operators, is to make double flaps when there is beneath a single bone (like the femur), and when there happen to be two parallel bones (like the tibia and fibula), to employ the circular operation. There is still a class of surgeons who give preference to flap operations in amputations wherever they can judiciously use them. The procedure of transfixing a limb and cutting outwards in forming flaps, has its warm advocates; and, on the other hand (especially in certain localities), the steps of the operation are reversed by the surgeons making their incisions from without inwards.

The French surgeons have modified the old circular operation by dividing in respect to layers (that they may fully retract), the integument and the muscles, each separately. They claim thereby that fewer ligatures are needed, for the vessels are severed transversely and not obliquely, as happens in the flap operation. The choice of the operation itself, or the mode of performing it, is usually the effect of education and habit. Accordingly, each varies in individual hands, and has its own peculiar merits. The highest aim of the surgeon should be to save as much of the injured parts as he consistently can, and still give his patient a useful stump. In order to accomplish this important object, it may become necessary to combine the steps of two operations, and in these special cases the ingenuity of the operator may be fully taxed. If he pays due regard to the relative anatomy of the locality, and is governed by sound surgical laws, success will surely crown his efforts.

It is not my province, in these remarks, to advocate the recommendation of any one operation over another in a particular section, nor do I believe such a course productive of benefit. The respective operations of Hey, Chopart, Syme, and Pirogoff, are to be put in practice when by the nature of the injury they are specially indicated. The most objectionable among these plans is the procedure demonstrated by Pirogoff, which in the hands of surgeons in this country has not proved propitious to its general adoption. In amputating the leg, a slight diversity of opinion still exists on the propriety of choosing between what was known in olden times as the "rich and poor man's stump."

In selecting the point at a hand's breadth below the knee-joint to operate, we secure sufficient material for a cushion to the stump, and to which a most useful and symmetrical artificial limb can be adjusted. The place of election being the lower third of the leg, where the soft parts are scanty, we gain a poor covering for the bones, and run the risk of having the cicatrix continually ulcerated by pressure. The theory of preserving as much of the limb as possible for the sake of beauty, has long since exploded, the mechanic having substituted an artificial leg, which, when covered by clothing, is fully equal in appearance to the natural limb. The long stump is again objectionable,

on the ground that it lacks strength when compared to the "poor man's stump."

The operation of amputation at the knee-joint is not practised by surgeons of the present day so commonly as in earlier times. The operation is selected when amputation of the leg is not admissible. The mode of operating in this locality is either to form a single flap from the posterior part of the leg, or else the circular procedure is employed. In either case the ends of the condyles of the femur are sliced off, the vessels are secured, and the flaps are brought in apposition. For practical purposes the stump thus formed cannot be excelled, but the danger to the patient is enhanced by exposing and disturbing the sensitive structures composing this great joint. The constitutional troubles generally arising from the operation under consideration are of the most serious character, and not unfrequently terminate speedily the patient's existence.

The majority of our most eminent surgeons prefer the flap operation in amputating the thigh, and to the observer it is certainly one of the most satisfactory operations in surgery. The character of the injury or the effects of disease may, however, be impassable barriers against the use of this single mode of operating in all instances. In these exceptional cases we are to be governed entirely by the surrounding circumstances in making the flaps, and, above all, we are to take care and not include unsound tissues in the newly formed stump. The selecting of the place to amputate the thigh may be followed by mighty consequences, for it is well known that the nearer the hip-joint the limb is removed, the greater is the danger, and, in a minor degree, the same may be said in approaching the knee-joint. The practice of always amputating a contused and mangled limb (as recommended by a late writer) because it is "a constant source of accumulating irritation," is a bad precedent to establish, it being at variance with our experience and also with conservative surgery. The great dangers to be apprehended and guarded against in amputating the thigh are those arising from the shock and constitutional irritation; locally, we may have secondary hæmorrhage, pressure, and ulceration, caused by the remaining portion of the femur (when the flaps are scanty, and the stump is not properly supported, the free end of the bone is prone to tilt upwards). Exfoliation of the sawn extremity of the remaining fragment, and, lastly, extensive inflammation and sloughing, may be a source of annoyance, and arrest the recovery of the patient.

In discussing the important subject of compound fractures of the thigh, too little stress has hitherto been paid by surgical writers to the saving of limbs. Following the teachings of Dupuytren, Baudens, Hennen, Guthrie, and a host of others, we are too ready to admit that amputation is our sole reliance. They would have us believe that the patients who save their limbs remain ever afterwards martyrs to a miserable existence; that for years fistulous openings, necrosed bone, shortening of the limb, gleet, sores, and shattered health, torment the sufferer, and finally end his career. Others inform us amputation of the thigh is a dangerous expedient, and in their hands has resulted, in the majority of cases, fatally, yet they carefully avoid entering into any details of their manner of treating these fractures. The wonder to my mind is, that their patients ever recovered when laboring under this species of injury, for in both England and France, according to my observation, they are sadly deficient in the modern mechanical appliances necessary to treat these fractures successfully. The surgeons of America are peculiarly expert in the treatment of fractures of the thigh, which, after much study to fully comprehend, they have reduced to a science. They are not, therefore, to be deterred in their progress by worn-out theories, or the dread of encountering necrosed bone and its usual train of troublesome symptoms. If the case is pronounced favorable for preserving the limb, it is submitted to a judicious system of treatment in some General Hospital. The removal of the

patient now becomes the object demanding our earnest attention, for at this early period of the injury, by negligence or carelessness, the condition of the sufferer can be rendered hazardous. The indications are, to place the parts in a natural position, keep them immovable, and dispense with snug bandages and splints. In addition to the common field-litter, I would recommend that one or two double inclined planes be furnished to the surgeon of each regiment. The double inclined plane should be similar to the pattern constantly used in our large civil hospitals, where we commonly meet with these injuries. The apparatus is so constructed that it will rest securely on the litter, and can easily be changed to either side, and thus made to accommodate itself to the fractured limb. It can be firmly secured to the litter by straps and buckles, or can be fastened by strips of bandage. The advantage gained by the use of this apparatus is, that it prevents the disturbing of the patient unnecessarily, and, also, it gives us free access to the wounds on applying fresh dressings, and when not in service it can easily be transported. The treatment of recent stumps is of far more importance than the mere steps of the operation, which can be readily learned and carried into execution. The former requires patience, experience, and skilful manipulation. It may be said with truth that on these details, more than the skill exemplified in operating, depends the patient's life. Before closing the flaps of the stump, be sure the hæmorrhage has ceased. If it is general from the fresh cut surface, it is prudent to leave the parts exposed to the air for a time, or bathe them with cold ice-water. Should the bleeding be continuous and flow from the cancellated structure of the bone, it can be arrested by a plug of beeswax or wood without injury. The dressings to be used should be light and secure, yet care must be taken to loosen them on the advent of inflammation and swelling. The great danger being from secondary hæmorrhage, we should avoid stretching the ligatures until a sufficient time has elapsed for them to become detached. In removing the adhesive straps they should first be loosened by bathing the parts with tepid water, and then with the forceps they should be seized and drawn towards the uniting wounds; an opposite course would tend to break down recent adhesions. Finally, in the treatment of the general and local symptoms as they arise in these cases, it remains for the surgeon to exercise his judgment to the best advantage of his patient.

EPILEPSY TREATED WITH IODIDE OF LEAD.

By W. W. ELY, M.D.,

OF ROCHESTER, N.Y.

PRACTICALLY considered, epilepsy presents two classes of cases—the curable and the incurable. Inveterate habit and certain pathological changes must ever render many cases of this formidable disease unmanageable. The curable class has been treated with some success by regimen, and by certain minerals and vegetable narcotics, without, however, establishing the reputation of any particular method or agent as decidedly anti-epileptic. The preparations of lead have not as yet had an extended trial in this disease; yet, from the peculiar and decided influence of this mineral on the nervous system, it is not unreasonable to suppose that it might prove of benefit. The only notice I have seen relating to the use of lead in epilepsy, is a statement by the late Prof. William Tully (*Mat. Med. and Therap.*, vol. i., p. 735), that he had known several cases of epilepsy successfully treated by the uniprotacetate of lead. He also suggests, from theoretical considerations, that the protocarbonate might prove more speedy and effectual, and adds that he has never verified this belief by actual trial.

The prompt and beneficial influence of the iodide of lead in two cases in which I have recently employed it, has led me to hope that it will be found on further trial worthy of the confidence of the profession in the treatment of this formidable disease. I may add, that the remedy in question was selected as a matter of convenience and without refer

ence to the supposed effect of the iodide. Yet I am satisfied that it is an eligible way of administering lead for its specific effects; and if any importance is attached to the *humoral* notions somewhat prevalent in regard to epilepsy, no objection, at least, can be urged against these two articles in combination.

G. B., a twin boy, born Oct., 1854, had a severe convulsion in July, 1861, another in December, and a third on May 2, 1862. From the latter date the attacks were manifestly epileptic, occurring generally at night, and every night, averaging five or six daily, until the following December. He was treated with a variety of remedies in addition to regimen, viz. mercurial cathartics and vermifuges, oxide of zinc, belladonna, quinia, iodide of potassium, a seton in the neck, etc. A paralysis of one side of the face suggested the probability of cerebral disease. After nearly all hope of benefiting him had been abandoned, and he had become almost a lunatic, I prescribed, Nov. 27, 1862, five grains of acetate of lead, three times a day, in an emulsion of castor oil. After a short time the medicine was discontinued on account of the obstinate constipation it induced. I then gave him the iodide of lead, two grains three times a day, and continued it until it caused severe enteralgia. After the occurrence of this symptom, in the latter part of December, his fits ceased, and have not returned. His mind is restored, and his general health is now good.

A son of Mr. W., aged 15, began to have convulsions at about three years of age. Up to his fifth year they were infrequent, and attributable to some exciting cause. From the seventh to the twelfth year they were more common, but consisted of slight spasms only. For the last three years they have been strongly epileptic every three or four weeks, numbering from ten to thirty at each period. In addition to dieting and palliative remedies, he took the oxide of zinc, thirty grains daily, for about three months, without the least apparent benefit. He then used twelve bottles of Pierlot's valerianate of ammonia, which proved only a palliative. For three or four months he took the ammoniuret of copper, with a similar result. In March last he commenced the use of the iodide of lead, five grains daily. About two weeks afterwards he had one fit and two slight spasms. The remedy was continued, increasing it to nine grains daily, until it produced severe enteralgia, when it was omitted. He has now passed over the usual periods without any attack of the disease, and appears to be improved in every respect. The effect of the medicine has been to moderate his appetite, which was formerly difficult to control. It has also reduced his weight from 138 to 124 pounds.

If any one should be induced, from this limited experience with lead, to make trial of it in epilepsy, I would suggest that the remedy be given until its specific effect on the bowels is obtained, and that the enteralgia be treated palliatively, *without opiates*, or be allowed to take its own course. The proper regimen should be enjoined on the patient. A stimulating diet, over-exertion, and mental excitements, prove prejudicial in many if not all cases of epilepsy.

June 13, 1868.

POSTURAL TREATMENT OF LABORS

WITH PROLAPSE OF THE UMBILICAL CORD.

BY JOSEPH MARTIN, M.D.

OF NEW YORK.

HAVING on two other occasions occupied the pages of the MEDICAL TIMES with the history of cases that illustrated Dr. T. G. Thomas's method of treating labors with prolapse of the umbilical cord, it is with some reluctance that I again bring the subject before the profession. But in looking over Professor G. S. Bedford's "Principles and Practice of Obstetrics," I find that the peculiar method of treating this complication, called by Dr. Thomas the postural treatment, has been merely alluded to in a note, as if it were

an untried practice. As might have been expected, from the well known ability of the writer, this treatise on midwifery has become a favorite text-book in the medical schools of this country. And as the life of the infant in such labors is always endangered and often sacrificed by the use of the forceps, as recommended by the above author, or by version, the favorite practice of other writers, while a large number of cases on record show that by the postural treatment, when properly managed, *the child is uniformly saved*, it would serve the cause of humanity if physicians who adopt the last mentioned method would publish every case that comes under their care.

A few days ago I was called to attend Mrs. M—, aged 29 years, in labor with her seventh child. She had experienced, before I saw her, moderate labor pains for several hours. The vertex presented at the superior strait, the head was in the left occipito-anterior position, and the os uteri open to the size of a dollar. As the head was not engaged in the pelvis no other examination was made for one hour, when the os was found fully dilated, and the membranous bag was distended, during pains, by an unusual amount of liquor amnii. The labor pains being now strong and frequent, and the head not entirely engaged, I waited a few minutes longer, when the waters were suddenly discharged; and immediately after the finger detected a large loop of the umbilical cord, which had slipped down on the left side of the child's head, near the right sacro-iliac synchondrosis.

I then explained to the patient and her family the nature of the difficulty, the necessity of removing it to save the life of the child, and the manner in which the operation would have to be performed. No objection was made to a change of position; and, after holding the cord between the two fingers, for the double purpose of preventing its further descent and observing its pulsations, until labor pains had forced the head as far into the cavity of the pelvis as could be permitted with safety to the child, the woman was placed in the position recommended by Dr. Thomas—that is, upon her knees, with her face and shoulders down upon the pillow. The left knee was brought close to the edge of the bed. And, as I stood by her side, the left hand was passed under the fundus of the uterus to support it and its contents during and in the absence of pains. The four fingers of the right hand were then introduced into the vagina, and an attempt was made to carry the prolapsed cord far enough down towards the pelvic opening to cause it to slip by its own gravity into the body of the uterus, but without success. The thumb was now introduced, and the whole hand was passed along the left side of the head, carrying downwards the cord until its coils could be felt as they lay upon the breast of the infant. At the same time the little finger rested upon the ear, and the backs of the fingers were pressed against the brim of the pelvis, at the right sacro-iliac synchondrosis. The hand was slowly withdrawn as the labor pains forced the head further into the pelvis. The patient was then turned upon her back, and in less than half an hour the child was born alive, as if there had been no complication.

I will leave it to the reader to decide whether the postural treatment, as illustrated by this case, is preferable or not to turning, and the use of instruments.

THE Congrès Scientifique of France will this year hold its session at Chambéry, from the 10th to the 20th of August. The programme of medical questions is as follows:—*Cretinism*: What is the use of hospitals for cretins? *Cemeteries*: Has experience shown that any influence has been produced as regards epidemics, etc., through the neighborhood of cemeteries? *Marshes*: Do the Marshes of Savoy produce pathogenic effects, etc.? *Medical Education*: Is medical science advanced in France by the multiplication of centres of instruction? *General Hydrology. Special Hydrology. Judicial Payments to Medical Experts, etc.*—*Brit. Med. Jour.*

Reports of Societies.

NEW YORK COUNTY MEDICAL SOCIETY.

STATED MEETING, May 4, 1863.

ALFRED UNDERHILL, M.D., PRESIDENT, IN THE CHAIR.

STIMULANTS IN TYPHOID FEVER.

DR. T. C. FINNELL opened the evening discussion on the treatment of typhoid and typhus fevers by inquiring—At what period of the disease in question the use of stimulants should be commenced? In his opinion this use was indicated at an early period of the malady. Some were in the habit of deferring them until nervous tremors manifested themselves, the tongue beginning to get dry and brown, and delirium and a quick pulse were ushered in. But he wished to know what were the real indications for their use?

DR. JOS. WOOSTER stated in reply that he was in the habit of giving stimulants very early in this disease, indeed as soon as the hepatic and other functional derangements shall have been corrected. All the varieties of typhoid and typhus fevers he considers to be the result of various sedative poisons diminishing the energies of the heart; thus requiring the antagonistic influence of stimulants in proportion to the various grades of depression.

DR. DOWNS advocated an early use of stimulants.

DR. THOMS stated that he was one of the out-door visiting physicians to the New York Dispensary. His district was bounded by Broadway, Spring, Delancey, Allen, Division, Bayard, and White streets. Within this district may be found some of the filthiest locations on Manhattan island. Dr. T. referred to cases of typhoid fever occurring in Nos. 214 and 216 Canal street, Nos. 77, 79, 81, 90, 106, 109, 113, 115, 132, 167, 172, and 188 Mulberry street, Nos. 90, 92, and 94 Baxter street, and Nos. 78, 106, and 195 Mott street, with a number of other cases scattered through the various streets of his district, and mentioned as a remarkable fact that nearly all of the cases he has attended dwelt in rear buildings.

DR. T. has seen whole families pass through the disease, and every inmate in whole buildings infected by it. The rear house No. 108 Mulberry street has not been free from typhoid fever for over one year.

He finds that his cases have as good a chance to recover without stimulants (for want of means) as hospital cases have with them. Uses quinine in small doses freely, as a substitute, and when he does use alcoholic stimulants gives Bourbon whiskey the preference.

DR. T. recommended that the profession would urge the importance of removing typhoid fever and similar patients, upon the authorities.

Reference was made to a number of cases of variola where the city physician, the health warden, and city inspector, had been informed of the same, but the only notice taken of the cases was a mere visit by the health warden of the district.

DR. CHAS. HENSCHEL remarked that many cases require no treatment at all. It is only in the graver forms that we are obliged to act energetically, and then stimulation is our sheet-anchor; but that anchor may be dropped too soon—when we once have begun with stimulants, we are obliged to go on and to increase them in quality and quantity. It is therefore safer, when we are in doubt whether the proper period for stimulation has arrived or not, to wait six or twelve hours, and then begin with the mildest—valerian, serpentaria, wine whey; or where there is a disposition to diarrhoea, brandy, if good, otherwise whiskey. Where little or no diarrhoea exists, with great pain in the abdomen, which is tympanitic and excessively sensitive to touch, frequent vomiting, and great thirst, ten grain doses of calomel once or twice repeated, rarely fail to give relief. In extreme cases Dr. H. has given phosphorus ranging in doses from the one-sixteenth to the one-eighth of a grain,

and in a few instances with success: never witnessed any bad effects from the same. In the versatile form of the disease, stimulants do no good; the chief remedies are shower-baths and musk.

DR. UNDERHILL referred to Prof. HUSS, of Stockholm, who in 3186 cases used nothing but phosphoric acid, and nearly all the cases recovered.

DR. GARRISH extolled the use of stimulants in typhoid and typhus, but finds that the greater part of the profession treat typhoid fever in the beginning too harshly, by giving harsh purgatives, mercurials, etc., etc. Dr. G. favors the administration of one or two blue pills, to be followed by an ecoprotic mixture; liquor ammoniac acetatis in ounce doses every third or fourth hour, and cool drinks. Insists on good ventilation, very few visitors, and gives generous support. As soon as the tongue begins to get dry and brown, recommends the carbonic acid water, which allays the thirst, and relieves the distressing pain in the back. At this period he suggests the administration of quinine, wine whey, whiskey, or the best of brandy, and plenty of beef-tea, prohibiting all visitors at this stage. Dr. G. is sure that the treatment is less at fault than the surroundings, and earnestly hoped that the removal of typhoid fever patients, as suggested by Dr. Thoms, be strongly urged upon the proper authorities by the profession.

DR. FINNELL was surprised to hear Dr. Garrish say that the majority of our physicians commenced the treatment of typhoid and typhus by giving mercurials and purgatives, stating that his experience had been otherwise.

In addition to his previous question, he would like to ask—What amount of stimulants is safe to administer? Is himself in the habit of giving definite directions as to the quantity and time of its administration. Usually directs that half an ounce be given at first every three hours, then the same quantity every two hours, and seldom exceeding half an ounce every hour when the disease is at the worst. Believes that through ignorance on the part of friends, and sometimes through carelessness on the part of the medical attendant, too much stimulant is given, which has the effect of producing local congestions that in themselves occasionally destroy the patient.

Related a case where it was very freely administered for several days with benefit, but while recovering from the fever, delirium tremens (if such a thing can follow typhoid fever) came on. In respect to phosphoric acid, he would state that it was now being used in those cases under treatment, and apparently with benefit.

DR. WOOSTER replied that very low fevers require frequently a quart of brandy, or a still larger amount of whiskey (now the most fashionable and most reliable stimulant), in the course of twenty-four hours, until the periodic limitation of the disease has arrived. He considers stimulation, nutrition, and ventilation, the chief requisites in the management of those fevers. This bold, stimulating course has been pursued by him for the last twenty years; and though in many cases he has felt that his patients had not sufficient stimulus, he has never had occasion to regret having given too much.

In one case only has he ever witnessed intoxication, and that was on the twenty-third day (in his absence from the patient), the quantity of stimulant not having been diminished as was usual after the twenty-first day. This had been an extremely low case, and he never saw a more rapid recovery.

DR. JAMES KENNEDY said that whatever opinion may be entertained regarding the pathological difference between typhoid and typhus fevers, there certainly could be but very little difference, if any, in the treatment. Remedies should always be addressed to symptoms, and not to names. The treatment of these two fevers, in his opinion, should be stimulating and tonic, with all the appliances necessary to sustain the system generally. A healthy location, a large room, well ventilated, which would admit plenty of fresh and wholesome air, quietude, and avoidance of all irritations of any kind.

At the commencement of the disease very little medicine will be required. A gentle alterative cathartic, *i.e.* a blue pill and a little magnesia, may be quite sufficient. At what time and to what extent stimulants and tonics should be given in this form of fever, must be determined very much by the skill, good sense, and judgment, of the attending physician. As a general rule bad symptoms are to be expected in typhus fever, and should be anticipated by the early use of remedies. Some years ago Dr. K. was called to visit, in consultation with three old and highly respectable physicians of large practice in this city, a young man. He found the patient laboring under symptoms indicating speedy dissolution: dry skin, brown-black tongue, furred and cracked, pulse rapid and tremulous, subsultus tendinum, delirium succeeded by stupor from which it was difficult to rouse him, petechia, jerking at the bed-clothes, involuntary discharges from the bowels and urinary bladder, etc., etc. Dr. K. inquired when those symptoms first appeared? Two or three days ago! was the answer. Infusions of serpentaria had been given, and the day before a small quantity of wine whey. Dr. K. advised to give the patient as much brandy and porter as they could without measure, beef-tea, quinine, and so forth. His suggestions were immediately adopted, and the next day the symptoms were more favorable, and the young man finally recovered.

The alcoholic stimulants preferred by Dr. K. are St. Croix and Jamaica rum, given either hot or cold, with sugar and water, or in the form of milk punch. Perhaps it would be as well to leave the selection of the liquor to be used, and the mode of its preparation, to the choice of the patient. Wine whey, beef-tea, quinine, acidulated drinks, etc., are the chief internal remedies. Sponging the surface of the body with warm vinegar and water or common whiskey will be found not only agreeable to the patient but of much service to him.

The success of the treatment will very much depend on the skill of the attending physician, and the knowledge and attention of the nurse. It is worthy of remark, the large quantities of stimulants some patients will not only tolerate but absolutely require at certain periods of this disease, and the vast difference between patients in that respect. While a pint of rum would be quite enough for one in twenty-four hours, another might require two, three, or four times that quantity in the same time.

Dr. JOEL FOSTER thinks that a smaller quantity of stimulants would answer, if only more beef-tea was given. Admits of no rule as to quantity or the time of commencing it.

TREATMENT FOR THE PEYERIAN LESION.

Dr. BENJAMIN LEE stated that no allusions had been made during the present discussion as to any treatment directed especially to the characteristic lesions of the disease under consideration. He referred to the intestinal complications known as ulceration of Peyer's patches. There can be no doubt that this ulceration interferes with nutrition, and the exhausting hæmorrhages thus resulting are often indirectly, and in some cases immediately responsible for the fatal result. While, then, the main treatment must evidently be directed to husbanding the patient's strength until the disease has exhausted itself, we are not justified in limiting our efforts to this while we have so evident and so alarming a local lesion to contend with, which may possibly be directly met.

Prof. Wood, of Philadelphia, as is well known, insists strongly on the oil of turpentine as better adapted than any other article in the materia medica to fulfil this indication. But whether the benefit derived from its use is to be attributed to this specific action, or rather to its general stimulating properties, is somewhat doubtful.

Other remedies, principally the astringents, have been suggested, but their success has not been great.

It occurred to Dr. L. during the past winter to see a manuscript paper by a former professor and well known

practitioner in this city, recommending the exhibition of arsenious acid in the solid form, in doses rather larger than the standard amount, with a view to meet this complication.

The remedy is advised to be used very early in the disease, and administered regularly, as often as twice daily. Care should be taken to give it only immediately after the ingestion of food in order that any local irritation of the coats of the stomach may be avoided, and to insure its rapid and complete assimilation.

The author claimed that the remedy acted not directly upon the mucous surface, but through the circulation, in giving tone to the capillary vessels of the mucous coats; thus not healing up the ulcers after they had formed, but preventing their formation. The result of his experiments is, that a much larger quantity of arsenious acid can be given in the solid form than in solution, without injury to the coats or the stomach or intestine, and especially if it be taken up with food. A sufficient number of cases were detailed to entitle the suggestion to a respectful consideration, but he was not yet prepared to make it public.

Dr. L. thinks, however, that he betrays no confidence in making this statement, and would request any member who may have hospital cases in which a trial would be admissible to bear it in mind.

Dr. Lee stated that he should not hesitate to make the experiment himself in any case that might present itself.

FOREIGN CORRESPONDENCE.

LETTER XXXVIII.

By PROF. CHARLES A. LEE.

VENICE—ITS CLIMATE, PHYSICAL HISTORY, MUD-BATHS, ENGLISH PHYSICIANS.

VENICE, Oct. 25, 1862.

In my previous letter I spoke of some of the peculiarities of the climate of Venice. Since then I have made other researches, which go to show that during a series of years snow has fallen on six days of the winter, and that although the hygrometer indicates a high degree of humidity, especially when the wind blows from the sea, yet that there are many maritime towns in southern Italy, frequented by invalids, which give a similar mean. This, indeed, is true of Rome and other towns at some distance from the sea, not surrounded by morasses. During a series of seven years the number of rainy days has not exceeded seventy-five, which is as low as in any part of southern Italy, while the annual quantity of rain is less than in many of the southern towns. The physicians here attribute many of the peculiarities of the Venetian climate to the influence of the north-east wind; for, besides dispersing the miasma, as already stated, it is said to be mainly influential in causing the vicissitudes of the weather, and the particular character of the annual climate. As it sweeps down from the northern part of the gulf, carrying before it all atmospheric impurities, it speedily brings on a copious rain, especially when it succeeds a warm and damp wind; not of long continuance often, when the sky clears up, and the atmosphere becomes pure, transparent, and mild. In winter the same wind is apt to bring snow. Often a terrific thunder-storm breaks over the gulf when the same wind encounters the blasts blowing from the sea, while, at the same time, the sun shines with splendor over the city, gilding all her domes and marble palaces.

I have alluded to the changes going on in the character of the Venetians, and even the expression of their features, from the tyrannical and iron rule of the Austrians. The climate, we know, must necessarily favor a life of indolence and voluptuous ease, a state of inertia in which the moral and physical energies are equally dormant; yet no one can take a retrospective view of Venetian history without admiring the lofty courage, the undaunted bravery, the heroic deeds, the wonderful achievements of this small republic

from its foundation, almost contemporary with that of Rome, down to the final extinction by Buonaparte in 1797. A tinge of melancholy, pride, and graceful dignity still shines prominently forth in the countenances of the descendants of the old nobility, but this is replaced by a malignant scowl of mingled scorn and hate at the sight of an Austrian soldier or the thought of Austrian rule. The marvellous silence which reigns over this city of 120,000 inhabitants is emblematic of her national extinction, and quite consonant with the death-like vitality of her people. Whether it is that these moral causes have modified and changed the physical character of the Venetians, I cannot say; but certain it is that they now exhibit the nervous temperament developed to the very highest degree. "To die of a rose in aromatic pain," might almost literally apply to the inhabitants of Venice. Nervous diseases are therefore most frequently met with. On this point the physicians here are all agreed; and they also admit that bloodletting has to be practised here with far more caution than in some other parts of Italy, as death not unfrequently supervenes on a fit of fainting consequent on loss of blood. So free is the city of intermittents, and so salubrious its climate considered, that it is not unusual for patients suffering from malarious fever to come here to recover from its attacks. The mildness and equability of the winter climate attract many patients here annually from the north of Europe, especially from England, who seem to relish greatly the quiet tranquillity and repose which prevail over the city; and it is said that some forms of paralysis, as well as neuralgic pains, are frequently benefited by a few months' residence. As adjuvants in the treatment of these affections, there are saline and mineral mud-baths, besides baths composed of sand and warm salt water, all of which are held in high esteem by the local physicians as producing stimulating and resolvent effects.

These mud-baths, by the way, are extremely popular in Italy. For instance, Abano, on the route from Mantua to Padua, is celebrated for its *muds*, as well as its warm mineral springs. These are applied either generally or partially, as the case of the patient may demand. These are thrown by after having been used, and, at the conclusion of the season, returned to the hot fountain, where they are left till the ensuing spring, that they may become impregnated anew with the mineral virtues which these are supposed to contain. The most obvious of these are salt and sulphur. The muds are, on being taken out, intensely hot, and must be kneaded and stirred some time before they can be borne. When applied—an operation which very much resembles taking a cast—they retain their heat without much sensible diminution for an hour or longer, having the effect of a slight *rubefacient* on the affected part, and producing a profuse perspiration over the whole body. Heat is considered as essentially aiding the operation of this treatment; hence it is generally abandoned about the end of August. The water-baths, as in Venice, are only regarded as auxiliary to the mud treatment, serving both as prologue and interlude, and, in my judgment, not unfrequently as a farce.

There are generally two or three English physicians resident practitioners in Venice, as there are, also, in most of the other large towns in Italy frequented by English tourists and invalids. These are very apt to recommend their respective localities as especially suited for English patients. Those in Venice tell us, with considerable plausibility, that Englishmen, who have acquired a torpid and lymphatic temperament by living under the leaden skies and humid atmosphere which tend to depress the nervous system, experience a favorable change under the bright skies and purer air of Venice. But, so far as my experience or knowledge goes, the character of the Venetian climate is decidedly sedative, and that without regard to the country from which the traveller or invalid may come. It was for this reason, probably, that the Roman gladiators were sent to this part of Italy to reduce their plethora,

diminish the excess of blood, and put them in good fighting condition, as related by Strabo. So far as I can ascertain, patients laboring under pulmonary consumption, except in its earliest stages, are not benefited by this climate, but the tubercular softening is much accelerated. So, also, patients who are much depressed, or debilitated from any disease, especially those of a sanguineous or irritable habit, will find the climatic influences too relaxing and prostrating. It is a very common practice here to prescribe decoctions of the marine confervæ, on the principle, I suppose, that every region ought to produce the remedies needed to cure the diseases of that locality. It is very possible that they may have some beneficial effect in scrofulous affections. There can be little doubt but that the Venetian climate is well suited to cases of bronchial inflammation, chronic catarrh, and spasmodic asthma. The portion of Venice which is preferred as residence for the consumptive invalids is also the liveliest and most beautiful quarter of the city, viz. the Piazza of St. Mark, the Piazzetta, and the greater portion of the Grand Canal as far as the Rialto.

The weather, since I came here, has been splendid: the temperature about 65°, neither too hot nor too cold; the atmosphere clear from clouds and vapor, and a transparency and purity of air that I have never seen surpassed in any part of the world. But I meet with tourists who have spent one or more winters in Italy, who tell me that the Italian climate is a humbug; that although October is a delightful month, the least objectionable of any in the whole year, yet that the winter climate is actually worse than that of England; that they are always chilly, and can nowhere find shelter from the piercing cold, etc. Much of this complaint may perhaps be attributed to the British habit of grumbling at everything out of their own country (even the roses here are too fragrant), but still more to the fact, that in more northern climes the houses are prepared for the severity of the weather, and thick carpets, good stoves or grates, well closed doors and windows, with bright sea-coal fires, enable the Englishman to defy the winter. Here it is said that the cold is more intense within the house than without, as not a single window or door is air-proof, and a bright fire only increases the number and chilliness of the various currents which rush through every chink and crevice. As testimony to this effect is pretty uniform, we may very safely conclude that a winter residence in any part of Italy is not without very serious drawbacks. On this point, however, I shall be better prepared to give an opinion after I have had some personal experience. I will, however, say, that in my judgment there is not a more pitiable sight in the world than that of patients far advanced in consumption wandering over Italy in search of health. They must have strange forebodings on visiting the cemeteries, which are crowded with the tombs of foreigners who came here for health, but who perished of phthisis. How can invalids who are always sensitive and irritable, generally unacquainted with the language, the people, and the habits of the country, expect to avoid a thousand vexations and trials, thus increasing the sufferings they had expected to mitigate, and hastening the progress of a malady they had confidently hoped the climate would retard or avert? Home, and its consolations, comforts, and conveniences, are too little prized by the invalid, who, seduced by the enchantment of distance, and the interested statements of local practitioners, relinquish the last chance and the last hope of recovery, to wander and perish among strangers in a distant land. We shall see, hereafter, that although the extreme range of temperature is not as great in Italy as in our own country, yet the changes and variations are frequent and sudden, and felt quite as sensitively, and probably more so, than with us. And then there are the fatigue, discomfort, and risk, attendant upon changing their place of residence as the seasons change, to say nothing of the mania of sight-seeing, which is constantly exposing them to risks and dangers of every kind.

I am satisfied much has yet to be learned regarding the effects of climates, and of change of climate, as influencing the progress of disease. It seems to me highly probable, if not absolutely certain, that nature has adapted the constitution of man to his hereditary climate, and that it is hardly consistent with nature's laws and operations that a person born in our country, when attacked with tubercular disease, can be cured by a foreign climate entirely different from his own. The mortality from consumption is vastly greater in warm than in cold countries. What is wanted is a *uniform*, not a *warm* climate. The latter always facilitates tubercular softening, and hastens the final termination. A change of climate necessitates acclimation, and thousands sink under the probationary process from fatigue and exhaustion. The greater sensitiveness to cold, from the increase of the nervous temperament, caused by greater heat, more than counterbalances the alleged good effects of warm climates. If a change is deemed advisable or necessary in consumption, let it be a change of air in the same climate where the patient and his ancestors were born, and not a violent transition to warm countries. There can be no doubt whatever that the climate of the United States, embracing the utmost variety from the great lakes and the St. Lawrence to the Gulf, and from the Atlantic to the Pacific, affords to the pulmonary invalid greater chances of recovery than can be found in Italy or any other section of the globe.

American Medical Times.

SATURDAY, JUNE 27, 1868.

SUICIDE OF ALLEGED CRIMINALS.

READERS of our city papers must have noticed the frequent instances of attempts at suicide by persons detained in confinement. These occurrences would not be worthy of remark if they were limited to prisoners awaiting the execution of the death-penalty, or even condemned to a long period of imprisonment. We should then have an adequate cause for the attempted self-destruction, for in all periods of history, criminals have been guilty of this crime. But in this instance the crime is more frequently attempted by quite another class of prisoners: they are those persons who are awaiting their trial, and who have been charged with grave crimes. In nearly every case the victim of self-destruction has left behind him an explanation of his last criminal act. The exciting cause, if it may be so designated, is confinement in the dreary, noisome cells of a City Prison. No sane person can be taken from the fresh air and sunlight, and be immured in these gloomy recesses, more dreary than the niches of a catacomb, for any considerable period, without coming to prefer life to death. Shut out from even a ray of sunlight, stifled by the dead and lifeless atmosphere of a living tomb, permitted no other liberty than to pace the length of his own body, the mind of the prisoner gradually loses its susceptibilities; the past with its pleasant memories aggravates the miseries of the passing hour, and the future takes coloring from the gloom and melancholy of the present. He implores to be put on trial, and either by acquittal or condemnation be relieved from the horrors of a living death. But courts do not hear his petition, and his case is adjourned for long weary months. Meanwhile the prisoner is gradually approaching suicidal mania or melan-

choly, and suddenly, and often unexpectedly, he takes the fatal step. As yet his guilt or innocence is unproved. This violent termination of his life is, however, in the public estimation, sufficient evidence of his guiltiness, and upon the poor man's memory is stamped the inefaceable stigma of crime.

It is a well established maxim of criminal law, that the accused shall be regarded as innocent until he is proved to be guilty. In this approved decision of our courts we have a beautiful illustration of justice leaning to the side of mercy. For, the mere arrest of a person charged with the commission of crime might be taken as presumptive evidence of his guilt; and for the general good, as well as protection of society, he might, with the greatest propriety, have been treated as a criminal until proven to be innocent. But mercy has so far tempered the decrees of justice that the humanitarian view has been universally adopted, and the accused stands before the court an innocent person until proved to be guilty.

It would seem to follow, as a natural sequence from this maxim, that persons arrested for crimes should be treated as if innocent; that they should be placed under such restraints, or bonds, as will simply insure their appearance in courts, and that they be not otherwise deprived of their liberty. It is but right that a person who is believed to be innocent, and who in the eye of the law is innocent, should have all the privileges of an innocent person. There would seem to be a manifest injustice in removing such persons even from their ordinary duties, and much more to subject them to confinement. It might with great propriety be added, that the citizen who allows himself to be accused of crime, and to be put on trial, yields sufficiently to the necessities of society without being subjected to any further humiliation until he is proved to be guilty. But practically the law reverses its own wise and humane maxim. It not only demands the arrest of the accused but condemns him, before trial, to a felon's or a murderer's cell. In close and solitary confinement, deprived of every social, domestic, and political privilege, the accused remains for months, and often for years, before the question of guilt is determined.

Our criminal jurisprudence should be radically changed. Either the accused should be immediately put on trial as soon as the necessary evidence is obtained, or he should be held to appear by suitable bonds. If restraint is absolutely necessary to insure that appearance in case of capital offences, provision should be made for his comfort in keeping with the spirit of the law, which as yet regards him as innocent of the alleged crime.

THE WEEK.

THE necessity of an ambulance system is again brought to the attention of the public by Dr. BOWDITCH, of Boston, and with a personal appeal rendered impressive by the illustration which he draws from his own bereavement. His son, LIEUT. BOWDITCH, was mortally wounded in the abdomen at Kelly's Ford, and, though left in the rear of the advancing column, received no assistance except what was accidentally afforded him. The ambulance which he finally reached had no water, the driver was ignorant and careless, and the wounded officer had neither proper nor adequate attention. It is surprising that the obstinacy of a single official should be allowed to prevent the organ-

ization of an ambulance system. The people should demand it, and with an authoritative voice. Congress and Cabinet should be flooded with petitions, and delegations from the people should personally urge this subject until a system is adopted.

THE recommendation of the *Illinois State Medical Society*, that the AMERICAN MEDICAL ASSOCIATION choose its President independently of the location of the individual meetings, is important, and should be adopted. This custom has already led to much embarrassment of the members, and local strife and jealousies in the profession. PROF. DAVIS took a manly stand in this matter, and his example is well worthy of future imitation.

THE Medical Board of Bellevue Hospital have reviewed their action recommending the creation of specialties in that institution, and have come to the very opposite conclusion. They now advise only an out-door department, where diseases may be classified as in a dispensary. A census of the hospital shows too few diseases of the kind referable to the several proposed specialties, and the Board prefers to retain those in their present positions.

THE Index to this volume will appear next week.

Correspondence.

THE MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

[To the Editor of the AMERICAN MEDICAL TIMES.]

NEW YORK, June 20, 1868.

SIR:—In reading over my report of the Fourteenth Annual Meeting of the American Medical Association, recently held in Chicago, and published in your issues of the sixth and thirteenth inst., it has occurred to me that there are a few matters of interest not touched upon, and one or two errors which an informal letter of this kind may serve to correct.

As sins of commission are usually regarded as more mischievous in their effects than those of omission, let us first proceed to correct the errors. Of these, the first which struck my attention was contained in the published resolutions of the Association with reference to the famous *calomel and tartar emetic order* of the Surgeon-General of the U. S. Army. The resolutions published in your Journal were indeed submitted, but after some five or six hours' debate they were rejected by a very considerable majority, and the following were finally adopted in their stead:—

Resolved, 1.—That this Association condemn, as unwise and unnecessary, the circular of the Surgeon-General prohibiting the further supply of Calomel and Tartar Emetic for use in the Army; and that we regard such an order as an indignity to the military surgeons, while it is in direct opposition to the opinions of the regular profession of medicine.

Resolved, 2.—That the withholding ordinary medicines from the army surgeons implies a want of confidence in their skill as a body, which, if true, calls for the prompt interposition of the proper authorities; but if the imputation of a want of skill is unfounded, as we believe it is, the refusal to supply proper medicines is wholly unjustifiable.

Resolved, 3.—That Circular No. 6 being impolitic and prejudicial to the interests of the service, it is the decided sense of this Association, that a due regard for the welfare of the Army requires, and we do, therefore, earnestly recommend, the rescission of that Circular, and the substitution of the more just and philosophical method of correcting abuses, if any exist, by holding each surgeon, individually, responsible for the proper discharge of his appropriate duties.

I was very much pleased with the position taken by Dr. S. S. Cox, of the U. S. Army, during the discussion on these resolutions. He took the ground that the order was issued as a matter of expedience by the Surgeon-General, and had no reference to the practice of medicine outside of the army. It was not a question whether calomel and

tartar emetic should be used in the practice of medicine, but whether, in the peculiar circumstances in which soldiers were placed, it would not be better to dispense entirely with their use. He deprecated any interference on the part of the profession outside of the army, and considered the army surgeons should be left to express their own dissatisfaction whenever they should feel any occasion to do so.

I cannot equally endorse the views of a delegate from Indiana, who, in endeavoring to defend the order of the Surgeon-General, went much further than he in deprecating the use of calomel under any circumstances. Without attempting to pause upon the soundness of this gentleman's views of physiology and therapeutics, I would merely state that, whether right or wrong, they were irrelevant to the subject under discussion.

The second error which I noticed is apparently a mere trivial one, but nevertheless should be corrected. I stated "That only one essay had been published which was worthy of the prize medal." It would be more correct to state that only one essay was submitted, and that this was deemed well worthy of the prize, which I believe is not a medal at all, but one hundred dollars in current funds. Of course it in no wise detracts from the great merits of Dr. Percy's paper that it had no competitors, but it shows a lamentable want of interest in this subject on the part of the profession at large.

Another illustration of this same want of interest on the part of the profession is to be found in the fact, that of some sixty delegates from the city of New York, only seven were present, viz. Drs. William N. Blakeman, Alfred Underhill, Henry S. Downs, John H. Griscom, E. S. F. Arnold, H. G. Davis, and Guido Furman, and from Long Island not one. Why is it that, in a body so respectable and influential as the American Medical Association, we do not find the names of such men as Professors Van Buren, Clarke, Metcalf, Dalton, Draper, Post, Barker, etc., etc.? Is not their interest and the interest of medical science identical? Let us hope that another year will witness a reform in this respect. Notwithstanding this dereliction on the part of New York city, the meeting of the Association was in the main well attended. Seventeen States, one Territory, and the Army and Navy were fully represented, making in all one hundred and eighty-nine delegates.

The Association was very fortunate in having so able and courteous a presiding officer as Dr. Wilson Jewell, of Penn. His retiring address, of which a synopsis is given in your report, was worthy of all praise. The chairman of the Committee of Arrangements, Dr. N. S. Davis, of Chicago, delivered the opening address, of which I also gave a synopsis. The labors of this gentleman in behalf of this Association have been far more arduous than has generally been supposed. I think I am perfectly safe in asserting that there would have been no meeting of the American Medical Association this year, had it not been for the efforts of Dr. D. As to the imputation that had been cast upon his loyalty, I am equally safe in asserting that they owe their origin entirely to personal animosity. His opening address was a sufficient rebuke to all such slander. As I have heard it intimated that it was only on the account of these imputations that Dr. Davis failed to be elected President of the Association, it may be interesting to your readers to know what are exactly the facts of the case. At the meeting of the Illinois State Med. Society, of 1860, the following resolutions were unanimously adopted:—

Whereas, The American Medical Association is a national Association, composed of delegates and members from all parts of the United States, meeting on terms of perfect equality:

Therefore, Resolved, That in the opinion of this Society, all the officers of the Association should be selected strictly with reference to merit, and without any regard to their place of residence.

Resolved, That the custom of selecting the President of the Association exclusively from the profession of the city in which the Annual Meeting is held, is not only derogatory to the general character of the organization, and calculated greatly to lessen the honor which should attach to that office, but past experience has shown that it leads directly to local divisions, jealousies, and injurious partisan strife.

Resolved, That the delegates from this Society to the Association, be instructed to use their influence to abrogate the custom alluded to in the preceding resolution.

Resolved, That the Secretary be directed to furnish copies of the foregoing resolutions to other State and Local Medical Societies, and ask their attention to the same.

In view of these resolutions Dr. Davis sent the following letter to the members of the nominating committee:

To the Members of the Nominating Committee of the American Medical Association.

Inclosed you will find a series of resolutions adopted by the Illinois State Medical Society at the regular annual meeting in 1860, and which have not been modified or rescinded. They accord fully with the sentiments which I have entertained and acted upon for many years. And if in accordance with the custom mentioned in the second resolution your committee should allude to my name as a candidate for the office of President, please be kind enough to immediately read this letter and the accompanying resolutions to the committee, with the assurance that, while such custom or precedent is followed, I cannot allow myself to become a candidate for that high position. I earnestly hope your committee will discard all former customs and precedents, and nominate all officers with sole reference to the principle embodied in the first resolution.

(Signed) N. S. DAVIS.

CHICAGO, JUNE 1, 1868.

Notwithstanding this protest on the part of Dr. Davis against the use of his name, he received eight of the seventeen votes cast by the committee, wanting one vote of the requisite number for election.

After the election of Dr. March the duties of the chair were divided about equally between himself and Vice-President Dr. Cox. From the paucity of their reports I judge the standing committees of the Association to be merely ingenious contrivances for bringing the names of their members into publicity, without imposing upon them any very arduous duties.

The very able paper of Dr. Andrews on "Diathesis in its Surgical Relations," was very favorably received. It did great credit to its author. The gratitude of the Association is due to the retiring Secretary, Dr. Hubbard, of Connecticut, for the very efficient and courteous manner in which he discharged the onerous duties of his position.

Propos of the position of secretary—it was a valuable suggestion of Dr. Davis, that a permanent secretary be appointed, in order that there might be some responsible custodian of the archives of the Society. It is to be hoped that such an appointment will be made. Another valuable suggestion was that contained in the resolution providing for the election of the officers of the Association at the end of each session for the ensuing year, thereby enabling the Society to enter upon its active duties as soon as convened, and also affording an opportunity for the newly elected officers to become thoroughly prepared for their duties before being called upon to discharge them.

The indefatigable efforts of Dr. Arnold, of Yonkers, N. Y., to compel railroad companies to make suitable provision in the event of accidents happening on their roads, deserve the grateful appreciation not only of the Association but of the community at large. Every railway train should be provided with such a supply of surgical appliances as are required in cases of accident, just as steamboats are required to carry a certain number of life-boats, buckets, and life-preservers, as safeguards against the accidents to which they are most liable.

I cannot close this letter without bearing testimony to the liberal and generous hospitality of our professional brethren of Chicago. Delightful evening entertainments were given by Drs. N. S. Davis, W. W. Allport, W. H. Byford, M. Parker, A. Groesbeck, W. Carr and son, and J. P. Ross. These entertainments were well attended, not only by the delegation but also by Chicago feminine beauties. Your correspondent is deeply indebted to the pro-

fession of Chicago, and their families, for many a happy hour.

Yours,

CORRESPONDENT.

Army Medical Intelligence.

GENERAL ORDERS, NO. 130.

WAR DEPARTMENT, ADJUTANT-GENERAL'S OFFICE, }
WASHINGTON, May 15, 1868.

In executing the provisions of General Orders, No. 105, from this Department, in regard to the selection of men for the Invalid Corps, Medical Inspectors, Surgeons in charge of Hospitals, Camps, Regiments, or of Boards of Enrolment, Military Commanders, and all others required to make the physical examination of men for the Invalid Corps, will be governed in their decisions by the following list of qualifications and disqualifications for admission into this corps:—

Physical Infirmities that do not disqualify enlisted men for service in the "Invalid Corps."

1. Paralysis, if confined to the left upper extremity, and the man's previous occupation fit him for the duty of clerk, orderly, &c.

2. Simple hypertrophy of the heart unaccompanied by valvular lesion; functional derangement of the stomach (dyspepsia); mild chronic diarrhoea; simple enlargement of the liver or spleen; a temporary ailment of the kidneys or bladder.

3. Chronic rheumatism, unless manifested by positive change of structure, wasting of the affected limb, or puffiness or distortion of the joints.

4. Pain, unless accompanied with manifest derangement of the general health, wasting of a limb, or other positive sign of disease.

5. Myopia, unless very decided or depending upon structural change of the eye.

6. Stammering, unless excessive and confirmed.

7. Loss of teeth or unsound teeth.

8. Torticollis.

9. Reducible hernia.

10. Hemorrhoids.

11. Stricture of the urethra.

12. Incontinence of urine.

13. Loss or complete atrophy of both testicles from any cause; permanent retention of one or both testicles within the inguinal canal.

14. Varicocele and cistocele.

15. Loss of left arm, left forearm or left hand, if the man be qualified for duty of clerk or orderly.

16. Loss of leg or foot, provided the man have the inclination and aptitude for service in a general hospital, and is recommended for that duty by a medical officer, or if qualified for the duty of clerk or orderly.

17. Old and irreducible dislocation of shoulder and elbow in which the bones have accommodated themselves to their new relations.

18. Muscular and cutaneous contraction of left arm, provided the man may be employed as clerk, orderly, or messenger.

19. Loss of left thumb; partial loss of either thumb.

20. Loss of first and second phalanges of all the fingers of the left hand.

21. Total loss of any two fingers of the same hand.

22. Total loss of index finger of right hand.

23. Permanent extension of any finger of the right hand; permanent extension or contraction of any finger of the left hand.

24. Adherent or united fingers.

25. Loss of any toe or toes except the great toe; all the toes joined together.

26. Deformities of the toes, if not sufficient to prevent walking.

27. Large, flat, ill-shaped feet that do not come within the designation of talipes valgus.

28. Varicose veins not accompanied with ulcerations.

29. Gunshot wounds or injuries not involving loss of function.

30. None of the foregoing infirmities disqualify officers for service in the Invalid Corps.

In all cases where the physical infirmities of officers or enlisted men come within the provisions of the above list, they will be recommended for transfer to, or enlistment in, the Invalid Corps; but no one will be admitted into this corps, whose previous record does not show that he is meritorious and deserving, and that he has complied with the provisions of General Orders, No. 105, War Department, Adjutant General's Office, 1863, authorizing an Invalid Corps.

Physical Infirmities that disqualify enlisted men for service in the Invalid Corps.

1. Manifest imbecility or insanity.
2. Epilepsy, if the seizures occur more frequently than once a month, and have obviously impaired the mental faculties.
3. Paralysis or chorea.
4. Acute or organic diseases of the brain or spinal cord; of the heart or lungs; of the stomach or intestines; of the liver or spleen; of the kidneys or bladder, sufficient to have impaired the general health, or so well marked as to leave no reasonable doubt of the man's incapacity for military service.
5. Confirmed consumption; cancer; aneurism of important arteries.
6. Inveterate and extensive disease of the skin.
7. Scrofula, or constitutional syphilis, which has resisted treatment and seriously impaired the general health.
8. Habitual or confirmed intemperance, or solitary vice, sufficient in degree to have materially enfeebled the constitution.
9. Great injuries or diseases of the skull, occasioning impairment of the intellectual faculties, epilepsy, or other serious nervous or spasmodic symptoms.
10. Total loss of sight, or other serious diseases of the eye, affecting its integrity and use.
11. Loss of nose, or deformity of nose, if sufficient seriously to obstruct respiration; ozæna, if dependent upon caries.
12. Deafness.
13. Dumbness; permanent loss of voice.
14. Total loss of tongue, partial loss, and hypertrophy or atrophy of tongue, if sufficient to make the speech unintelligible, and prevent mastication or deglutition.
15. Incurable deformities of either jaw, whether congenital or produced by accident, which would prevent mastication and greatly injure the speech.
16. Tumors of the neck impeding respiration or deglutition; fistula of larynx or trachea.
17. Deformity of the chest, sufficient to impede respiration, or to prevent the carrying of arms and military equipments; caries of the ribs; gunshot wound of the lung, if complicated with fracture of a rib.
18. Artificial anus; severe stricture of the rectum.
19. Total loss, or nearly total loss, of penis; epispadia, or hypospadia, at the middle or nearer the root of penis; stone in the bladder.
20. Confirmed or malignant sarcocele; hydrocele, if complicated with organic disease of the testis.
21. Excessive anterior or posterior curvature of spine; caries of the spine; lumbar abscess.
22. Loss of a thigh.
23. Wounds, fractures, tumors, atrophy of a limb, or chronic diseases of the joints or bone that would prevent marching or any considerable muscular exertion.
24. Ankylosis, or irreducible dislocation of the shoulder, elbow, wrist, hip, knee, or ankle-joint.
25. Muscular or cutaneous contractions from wounds or

burns in degree sufficient to prevent useful motion of the right arm or of the lower extremities.

26. With the exception of those paragraphs which refer to the total or partial loss of an extremity, the foregoing disabilities disqualify officers as well as enlisted men for service in the Invalid Corps.

In all cases where the physical infirmities of an officer or enlisted man come within the provisions of this list, or where his previous record shows that he is not entitled to be received into the Invalid Corps, he will, if in service, be discharged, and if an applicant to re-enter, his application will be disapproved.

Whilst the government is most anxious to provide for and employ, to the best of their abilities, those faithful soldiers who, from wounds or the hardships of war, are no longer able to perform active duty in the field, yet it can, upon no account, permit men, undeserving or totally disabled, to re-enter its service.

Those faithful soldiers whose physical infirmities are too great to admit of their being of any use in the Invalid Corps will, nevertheless, receive the pensions and bounties provided by law.

It is further announced that no officer or enlisted man shall be entitled to or receive any pension, premium, or bounty, for enlistment, re-enlistment, or service in the Invalid Corps. They will receive all other pay and allowances now authorized by law for the U. S. Infantry except the increased pay for re-enlistment. Claims for pensions or bounties which may be due for previous service will not be invalidated by enlistment in the Invalid Corps. But no pensions can be drawn or accrue to the benefit of any man during his service in said Corps. The officers and men will be organized into Companies of Infantry, of the same strength as is now authorized by law for the U. S. Infantry. No organized Brigades, Regiments, Companies, or parts of Companies, will be accepted as such. Enlistments in this corps will be for three years, unless sooner discharged.

By order of the Secretary of War.

E. D. TOWNSEND,
Assistant Adjutant-General.

ORDERS, CHANGES, &c.

Leave of absence for thirty days has been granted to Surgeon G. W. Jackson, 53d Pennsylvania Vols.

So much of Special Orders 205, current series, Adjutant-General's Office, as dismissed Surgeon J. C. Bassett, 29th Massachusetts Vols., has been revoked, he having been previously honorably discharged by S. O. No. 35, Headquarters 9th Army Corps.

Surgeon E. P. Gray, 78th New York Vols., has been transferred to one of the regiments of U. S. colored troops to be organized under Brig. General Uman, U.S.V.; General Uman, U.S.V., will designate the regiment to which Surgeon Gray will be assigned.

Surgeon James L. Farley, 84th New York Vols., having been absent, sick, for a period of over four months, has been honorably discharged for physical disability.

Leave of absence for twenty days has been granted to Surgeon Henry Bryant, U.S.V.

Assistant-Surgeons John Bradley, Robert Reyburn, Alexander M. Speer, S. E. Fuller, G. F. French, and R. A. O'Connell, have been promoted Surgeons of Volunteers to date from June 13, 1863.

The order revoking the appointment of Assistant-Surgeon A. C. Schwarzwelder, has been annulled, and he has been ordered to resume his duties in charge of the Shumard Hospital at Hickman, Ky.

Surgeon W. S. King, U.S.A., recently Chief Medical Officer at Philadelphia, Pa., has been ordered to report to General Darius N. Couch, commanding Department of the Susquehanna, for duty as Medical Director.

Surgeon Josiah Simpson, U.S.A., has returned from Chicago, Ill., where he went as delegate to the American Medical Association, and has resumed his duty as Medical Director of the Middle Department, at Baltimore, Md.

Surgeon George S. Kemble, U.S.V., recently restored, and now awaiting orders at Ligonier, Westmoreland Co., Pa., has been ordered to report in person to Major-General Grant, commanding Department of the Tennessee, and by letter to Assistant Surgeon-General Wood, at St. Louis, Mo.

Assistant-Surgeon C. C. Byrne, U.S.A., now waiting orders in Washington, D. C., has been ordered to report in person to Major-General Roscreans, commanding Department of the Cumberland, and by letter to the Assistant Surgeon-General, at St. Louis, Mo.

Surgeon E. Swift, U.S.A., has relieved Surgeon W. S. King, U.S.A., in charge of the affairs of the Medical Department of the army, at Philadelphia, Pa.

Surgeon B. A. Vanderkift has been assigned to the charge of U.S. General Hospital, Division No. 1 (formerly Naval Academy), instead of St. John's College Hospital, as reported in our paper of the 18th inst.

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ERRATUM.—In No. XXV., June 20th, on page 300, first column, eighth line, for "jurisprudence," read "jurisdiction."

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 15th day of June to the 23d day of June, 1863.

Deaths.—Men, 57; women, 71; boys, 119; girls, 113; total, 360. Adults, 158; children, 232; males, 206; females, 184; colored, 6. Infants under two years of age, 136. Children born of native parents, 20; foreign, 166.

Among the causes of death we notice:—Apoplexy, 6; infantile convulsions, 40; croup, 13; diphtherite, 16; scarlet fever, 20; typhus and typhoid fevers, 16; consumption, 40; small-pox, 5; measles, 11; dropsy in head, 16; infantile marasmus, 20; cholera infantum, 7; inflammation of brain, 12; of bowels, 17; of lungs, 8; bronchitis, 10; congestion of brain, 0; of lungs, 9; erysipelas, 2; diarrhoea and dysentery, 12. 206 deaths occurred from acute diseases, and 30 from violent causes. 273 were native, and 117 foreign; of whom 81 came from Ireland; 48 died in the City Charities; of whom 7 were in Bellevue Hospital, and 19 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

June, 1863.	SIX A.M.				TWO P.M.				TEN P.M.			
	Minimum Temperature.	Evaporation.	Barometer.	Wind.	Minimum Temperature.	Evaporation.	Barometer.	Wind.	Minimum Temperature.	Evaporation.	Barometer.	Wind.
15th.	65 70	8	29.90	S.W.	88 13	29.84	S.	80 7	29.86	S.		
16th.	55 58	10	29.95	N.W.	80 20	29.95	W.	70 13	29.91	N.W.		
17th.	53 68	9	29.81	S.W.	60 8	29.70	N.E.	57 5	29.60	N.E.		
18th.	57 63	4	29.64	S.W.	76 9	29.70	S. by E.	63 4	29.71	S.		
19th.	53 64	4	29.76	N.E.	66 9	29.82	N.E.	54 6	29.86	N.E.		
20th.	48 52	7	29.96	N.E.	61 10	29.96	E.	50 6	29.97	N.E.		
21st.	47 51	6	29.97	N.E.	56 9	29.97	E.	53 4	29.95	N.E.		

REMARKS.—15th, Clear. 16th, Clear, with fresh wind, driest day of the season. 17th, Clear sunrise; rainy after 10; severe storm, thunder and lightning from 5 to 6 p.m. 18th, Variable day; light rain at night. 19th, Cloudy with fresh wind; rainy A.M. 20th, Cloudy with fresh wind. 21st, Cloudy; wind mostly fresh; light rain evening; hard rain at night. Rain for the week, an inch; for week ending June 14th, half an inch.

SPECIAL NOTICES.

NEW YORK ACADEMY OF MEDICINE.—On Wednesday Evening, July 1st, Discussion on the Paper of DR. FLINT on the Use of Alcoholic Stimulants in Tuberculosis, by Drs. J. M. SMITH, H. GREEN, PEASLEE, LEAMING, and others.

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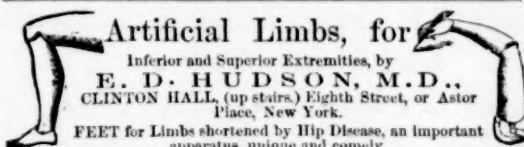
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